SERFF Tracking Number:	*HULI-125724845*	*State:*	*Arkansas*
Filing Company:	*Wilton Reassurance Company*	*State Tracking Number:*	*35989*
Company Tracking Number:	*WR-TL-APP100A*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.313 Decreasing - Single Life - Fixed/Indeterminate Premium*
Product Name:	*Term Life to Age 65*		
Project Name/Number:	*LF65/WR-TL-APP100A*		

Filing at a Glance

Company: Wilton Reassurance Company

Product Name: Term Life to Age 65	SERFF Tr Num: HULI-125724845	State: ArkansasLH
TOI: L04I Individual Life - Term	SERFF Status: Closed	State Tr Num: 35989
Sub-TOI: L04I.313 Decreasing - Single Life - Fixed/Indeterminate Premium	Co Tr Num: WR-TL-APP100A	State Status: Approved-Closed
Filing Type: Form	Co Status: Submitted	Reviewer(s): Linda Bird
	Author: Kim Hiar	Disposition Date: 07/15/2008
	Date Submitted: 07/11/2008	Disposition Status: Approved
Implementation Date Requested: 07/15/2008		Implementation Date:

State Filing Description:

General Information

Project Name: LF65	Status of Filing in Domicile: Not Filed
Project Number: WR-TL-APP100A	Date Approved in Domicile:
Requested Filing Mode: File & Use	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 07/15/2008	
State Status Changed: 07/15/2008	Deemer Date:
Corresponding Filing Tracking Number:	

Filing Description:

This application will be used with policy form WR-TL-POL100A, which was approved for use in Arkansas on June 3, 2008. It will replace application, WR-TL-APP110A-02.

The authorization portion of the application has been revised to comply with the federal HIPAA guidelines. The following sentence has been added to the authorization section: "I understand that any information that is disclosed pursuant to this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information,

but it will not be re-disclosed by the company except as authorized by me or as required by law."

Company and Contact

Filing Contact Information

Kim Hiar, Compliance Manager
1805 Monument Avenue
Richmond, VA 23220

kimberly.hiar@heritageunion.com
(804) 212-2818 [Phone]
(804) 213-0051[FAX]

Filing Company Information

Wilton Reassurance Company
187 Danbury Road
Riverview Building
Wilton, CT 06897
(203) 762-4438 ext. [Phone]

CoCode: 66133
Group Code: 4213

Group Name:
FEIN Number: 41-1760577

State of Domicile: Minnesota
Company Type: L&H

State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$20.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Wilton Reassurance Company	$20.00	07/11/2008	21363780

SERFF Tracking Number:	*HULI-125724845*	*State:*	*Arkansas*
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Product Name:	*Term Life to Age 65*		
Project Name/Number:	*LF65/WR-TL-APP100A*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	07/15/2008	07/15/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Linda Bird	07/14/2008	07/14/2008	Kim Hiar	07/15/2008	07/15/2008

SERFF Tracking Number:	*HULI-125724845*	*State:*	*Arkansas*
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Product Name:	*Term Life to Age 65*		
Project Name/Number:	*LF65/WR-TL-APP100A*		

Disposition

Disposition Date: 07/15/2008
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*HULI-125724845*	*State:*	*Arkansas*
Filing Company:	*Wilton Reassurance Company*	*State Tracking Number:*	*35989*
Company Tracking Number:	*WR-TL-APP100A*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.313 Decreasing - Single Life - Fixed/Indeterminate Premium*
Product Name:	*Term Life to Age 65*		
Project Name/Number:	*LF65/WR-TL-APP100A*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Third Party Authorization Letter		Yes
Form *(revised)*	Term Life Application		Yes
Form	Term Life Application		Yes

SERFF Tracking Number:	*HULI-125724845*	*State:*	*Arkansas*
Filing Company:	*Wilton Reassurance Company*	*State Tracking Number:*	*35989*
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TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.313 Decreasing - Single Life - Fixed/Indeterminate Premium*
Product Name:	*Term Life to Age 65*		
Project Name/Number:	*LF65/WR-TL-APP100A*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	07/14/2008
Submitted Date	07/14/2008
Respond By Date	

Dear Kim Hiar,

This will acknowledge receipt of the captioned filing.

Objection 1

- Term Life Application (Form)

Comment: The Term Life application was not attached to the form schedule.

Please feel free to contact me if you have questions.
Sincerely,
Linda Bird

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/15/2008
Submitted Date	07/15/2008

Dear Linda Bird,

Comments:

Response 1

Comments: I have attached the appropriate document.

Related Objection 1

Applies To:

- Term Life Application (Form)

Comment:

The Term Life application was not attached to the form schedule.

SERFF Tracking Number:	*HULI-125724845*	*State:*	*Arkansas*
Filing Company:	*Wilton Reassurance Company*	*State Tracking Number:*	*35989*
Company Tracking Number:	*WR-TL-APP100A*		
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Product Name:	*Term Life to Age 65*		
Project Name/Number:	*LF65/WR-TL-APP100A*		

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Term Life Application	WR-TL-APP110A-03		Application/Enrollment Form	Initial		51	WR TL-APP110A-03 Term Application.pdf
Previous Version							
Term Life Application	*WR-TL-APP110A-03*		*Application/Enrollment Form*	*Initial*		*51*	

No Rate/Rule Schedule items changed.

Sincerely,
Kim Hiar

SERFF Tracking Number:	*HULI-125724845*	*State:*	*Arkansas*
Filing Company:	*Wilton Reassurance Company*	*State Tracking Number:*	*35989*
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TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.313 Decreasing - Single Life - Fixed/Indeterminate Premium*
Product Name:	*Term Life to Age 65*		
Project Name/Number:	*LF65/WR-TL-APP100A*		

Form Schedule

Lead Form Number: WR-TL-APP110A-03

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	WR-TL-APP110A-03	Application/ Enrollment Form	Term Life Application	Initial		51	WR TL-APP110A-03 Term Application.pdf

SalaryShield®
Life Insurance Application

WILTON REASSURANCE COMPANY
A Minnesota domestic company

ABOUT PROPOSED INSURED (Please answer each question completely)

First Name _____

Last Name _____

Street _____

City _____ State____ Zip _____

Primary Phone _____
Best time to call: ☐ Morning ☐ Afternoon ☐ Early Evening

Alternate Phone _____
Best time to call: ☐ Morning ☐ Afternoon ☐ Early Evening

Current Occupation _____

Annual Salary $ _____ ☐ Male ☐ Female

SalaryShield Elite Term Life Insurance

Choose Coverage Percentage: ☐ 50% ☐ 75% ☐ 100%

Date of Birth _____ (month day year) Age _____ Birthplace _____ (state or country)

Height ___ feet _____ inches Weight _____ pounds

SS# _____

Driver's License # _____ State Issued _____

Are you a citizen of the United States? ☐ Yes ☐ No

If no, do you have a permanent Visa (green card)? ☐ Yes ☐ No

POLICY OWNER'S INFORMATION (If different from Proposed Insured)

Policy Owner's Name: _____

Policy Owner's Street: _____

Policy Owner's City _____ State____ Zip _____

Policy Owner's SS# or Tax Payer ID#: _____

PRIMARY BENEFICIARY INFORMATION

Name: _____

Relationship: _____

INSURANCE HISTORY (Check YES or NO for each question)

1. By applying for the proposed policy do you intend to replace, discontinue or change an existing policy or contract, or do you have other life insurance applications pending with any other company? ☐ Yes ☐ No
If yes, provide details as follows. Attach a separate sheet if more space is needed (*Indicate Type of Coverage: I=Individual; B=Business; or G=Group)

INSURED NAME	INSURANCE COMPANY	POLICY NO.	AMOUNT	*TYPE	PENDING	ISSUE DATE
					☐	
					☐	

2. Have you ever used any form of tobacco or nicotine products? ☐ Yes ☐ No
If yes, please furnish date of last use: Month: _____ Year: _____

3. Within the past 3 years, have you been refused life insurance or been issued a policy on a modified or rated basis? ☐ Yes ☐ No

4. Within the past 2 years, have you participated in activities involving piloting private aircraft, mountain or rock climbing, skydiving, skin or scuba diving or competitive racing of powered vehicles? ☐ Yes ☐ No

5. Have you ever been convicted of a felony? ☐ Yes ☐ No

If you answered "Yes" to question 3-5, provide details below. Attach a separate sheet if more space is needed.

QUESTION NO.	DETAILS

MEDICAL HISTORY (Check YES or NO for each question)

6. Have you ever had or been treated for depression, anxiety or any psychological disorder, epilepsy, nervous or mental condition, Alzheimer's or dementia? ☐ Yes ☐ No

7. Have you ever received any advice or treatment for alcoholism, drug addiction, drug abuse or other substance abuse? ☐ Yes ☐ No

8. Within the past 10 years, have you been treated or taken prescription medication for:
a. Heart or circulatory disorder, stroke, heart attack? ☐ Yes ☐ No
b. High blood pressure, elevated cholesterol, kidney disease, asthma, emphysema, sleep apnea, or other respiratory or lung disorder? ☐ Yes ☐ No
c. Cancer, leukemia, tumor, gastrointestinal disorder (ulcers), or diabetes? ☐ Yes ☐ No

(Continued on reverse side)

9. Have you ever been treated for or been diagnosed as having AIDS (Acquired Immune Deficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection or have you had test results indicating exposure to the AIDS virus? ☐ Yes ☐ No

10. Have any of your immediate family members (parents or siblings) been diagnosed or died from coronary artery disease, cancer or diabetes prior to age 60? ☐ Yes ☐ No

11. Have you ever been disabled or, have you ever made a claim or received benefits for disability or worker's compensation as a result of sickness or injury? ☐ Yes ☐ No

12. In the last 5 years, have you:

a. Been confined to a hospital or medical facility of any kind? ☐ Yes ☐ No

b. Had an x-ray, electrocardiogram, blood test or any other laboratory tests? ☐ Yes ☐ No

c. Taken prescription drugs for longer than 15 days? ☐ Yes ☐ No

13. In the last 2 years, have you been advised to have surgery or treatment? ☐ Yes ☐ No

If you answered "Yes" to any question from 6 through 13 above, you must give details below. Attach a separate sheet if more space is needed.

QUESTION NO.	PHYSICIAN OR FACILITY NAME/ADDRESS/TELEPHONE	REASON SEEN AND RESULTS OF VISIT (Include specific condition, duration, diagnosis, date last seen, treatment given, medication prescribed)

PAYMENT OPTIONS (Choose One):

Payer: ☐ Proposed Insured ☐ Policy Owner (if different than proposed insured) Choose a billing frequency: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

Choose a payment option:

☐ Credit Card ☐ Electronic Funds Transfer ☐ Bill Me Later (not available monthly)

Agreement/Authorization to Obtain and Disclose Information: I have read all the questions and answers on this application. All responses are true and complete to the best of my knowledge and belief. A copy of this application will be attached to and made a part of the insurance contract. Any insurance issued as a result of this application will not take effect until the full first premium is paid and a policy is delivered to and accepted by the Proposed Insured during his/her lifetime and while such person is in the state of health described in all parts of this application. I acknowledge receiving the "NOTIFICATION" regarding MIB, Inc. and Fair Credit Reporting Act in the enclosed materials. For use in determining insurability, I authorize any licensed physician, medical practitioner, MIB, Inc., any pharmacy related service organization, or consumer reporting agency that has any records or knowledge of the Proposed Insured's medical history to give any such information to Wilton Reassurance Company, its representatives, or reinsurers. This authorization is valid for 24 months from the date signed. A photocopy or facsimile of this authorization will be as valid as the original. I may revoke this authorization for information not then obtained by notifying the Company in writing. Such revocation will not be effective until received by the Company. I understand that any information that is disclosed pursuant to this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by the company except as authorized by me or as required by law. I understand that I or any authorized representative will receive a copy of this authorization upon request. I understand that I may request to be interviewed in connection with the preparation of an investigative consumer report. All applications are subject to underwriting approval which may include, but is not limited to, income verification, medical examination, laboratory testing, MVR, prescription records, and telephone interview.

Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **CO Residents**: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to fraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. **DC Residents**: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include, imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant. **KY Residents**: Any person who knowingly and with intent to defraud any insurance company or other person files and application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. **OH Residents**: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement is guilty of insurance fraud. **PA Residents**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signed at City _____ State _____ Date _____

Signature of Proposed Insured (Required – Do not print) _____

Policy Owner Signature (If Different than Proposed Insured) _____

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Product Name:	*Term Life to Age 65*		
Project Name/Number:	*LF65/WR-TL-APP100A*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*HULI-125724845*	*State:*	*Arkansas*
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Product Name:	*Term Life to Age 65*		
Project Name/Number:	*LF65/WR-TL-APP100A*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 07/08/2008

Comments:

Attachment:

Certification of Compliance - WR-TL-APP110-03.pdf

Review Status:

Satisfied -Name: Application 07/08/2008

Comments:

The application has been attached to the Form Schedule tab.

Review Status:

Satisfied -Name: Third Party Authorization Letter 07/11/2008

Comments:

Attachment:

WR Third Party Authorization Letter 26Mar08.pdf

CERTIFICATION OF COMPLIANCE

I certify that in preparation of this filing all statutes, regulations, rules and bulletins have been reviewed, including Rule 19 and Rule 49.

I also certify that all forms contained in this filing comply with the minimum flesch score of 40 as required in Arkansas ACA 23-80-206.

Signature

July 11, 2008

Date

Enrico Treglio

Name

Sr. Vice President

Title

Wilton Re | 187 Danbury Road Riverview Building Wilton, CT 06897

March 26, 2008

NAIC Company Code: 66133

Re: See Attached Forms Listing

Please accept this letter as authorization from Wilton Reassurance Company for Heritage Union Services, LLC. to file any or all policy forms as referenced on the attached form listing on behalf of Wilton Reassurance Company.

Sincerely,

Enrico J. Treglia
Senior Vice President and
Chief Operating Officer
Wilton Reassurance Company

etreglia@wiltonre.com t: 203.762.4438 f: 203.762.4439